Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Krishnan, Sumant G

Respondent Name
City of Arlington

MFDR Tracking Number
M4-07-0429-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 15, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "underpaid."

Amount in Dispute: $234.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "pd per MFG PPO Discount taken per Rule 134.202(d)(3).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 19, 2005	23410	$234.81	$234.81

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contracted/legislated fee arrangement.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202(d) states "in all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)." In regards to 45 – "The charges have been priced in accordance to a contract owned or access

by a First Health Co.", the services in dispute were reduced with this explanation code. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute. Therefore the disputed services will be reviewed per applicable rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.202(c)(1) states in pertinent part, "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." The disputed charges will be reviewed per applicable rules and fee guidelines.

Date of Service	Submitted Code	Billed Amount	MAR
December 19, 2005	23410	3,402.00	Physician fee schedule allowable for Dallas, Texas multiplied by 125% or $939.30 x 125% = 1174.13
		$3,402.00	$1,174.13

The total MAR for the disputed services is $1,174.13. The carrier previously paid $939.30. The requestor is seeking $234.81.This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $234.81.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $234.81 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 21, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.